For DASA use only

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Check No._____ Application No ▪ ☐☐ ☐☐☐☐☐☐

APPLICATION FOR CERTIFICATION
AS A NEW CHEMICAL DEPENDENCY SERVICE PROVIDER

Division of Alcohol and Substance Abuse (DASA)
Department of Social and Health Services (DSHS)
Olympia, Washington

Please complete **PARTS 1 through 6** of the application form, return the completed form with the completed information, and the required materials and $500 application fee.

PART 1 – AGENCY INFORMATION (See instructions at back of application)

1. Name of Agency (See instructions)

2. Additional Organizational Title (See instructions)

3. Street Address **City** **State** **Zip Code**

_____

3a. ☐ **Street address to be submitted at a later date**

4. Mailing Address (if different from street address) **City** **State** **Zip Code**

_____

4a. ☐ **Application mailing address only, and agency mailing address will be submitted at a later date, or,**
Personal address: ☐ **yes** ☐ **no**
4b. ☐ **To be agency mailing address at time of certification**

5. Telephone Number (Include area code)

(_____) _____

(_____) _____

5a. ☐ **Application contact telephone number only, and agency telephone number will be submitted at a later date. Personal telephone:** ☐ **yes** ☐ **no,**
or,
5b. ☐ **To be agency telephone number at the time of certification.**

6. Fax Number (Include area code)

(_____) _____

6a. ☐ **Application fax number only, and agency fax number will be submitted at a later date. Personal fax:** ☐ **yes** ☐ **no,**
or,
6b. ☐ **To be agency fax number at time of certification**

7. TDD Number (Include area code)

(_____) _____

7a. ☐ **TDD number to be submitted at a later date**

8. E-Mail Address

_____@_____

8a. ☐ **Application e-mail address only, and agency e-mail address will be submitted at a later date. Personal e-mail address:** ☐ **yes** ☐ **no**
or,
8b. ☐ **To be agency e-mail address at time of certification**

9. On-site Administrator's Name _____ 9a. ☐ Name will be submitted at a later date	9b. Title
10. Clinical Supervisor's Name _____ 10a. ☐ Name will be submitted at a later date	10b. Title

PART 2 – PROVIDER INFORMATION (See instructions at back of application)

Type of Ownership

Please indicate the type of ownership for the proposed agency:

Publicly Owned:

☐ City Government Name: _____
☐ County Government Name: _____
☐ State Government Name: _____
☐ Federal Government Name: _____
☐ Tribal Government Name: _____
☐ Health District Name: _____
☐ Educational Service District Name: _____
☐ Municipal Court Probation Name: _____
☐ District Court Probation Name: _____

Privately Owned:

☐ Sole Proprietorship Name: _____
☐ Partnership Name: _____
☐ Limited Liability Company Name: _____
☐ Non-Profit Corporation Name: _____
☐ For-Profit Corporation Name: _____

All providers:

Federal Employer Tax Identification Number (FEIN) (May use Social Security Number (SSN) if Sole Proprietor):

☐ FEIN ☐ SSN	

What person or entity is the final authority for your organization and will be responsible for the governing body requirements of Washington Administrative Code (WAC) 388-805-140?

Name:	Title:

Note: This can be an entity, such as a tribal council, county commissioners, corporate board, etc.

Privately owned providers only:

Washington State Uniform Business Identification Number:

☐☐☐ ☐☐☐ ☐☐☐

PART 3 – CHEMICAL DEPENDENCY SERVICES (See instructions at back of application)

DETOX AND RESIDENTIAL SERVICES	TOTAL # OF BEDS	SPECIAL TREATMENT FOCUS
☐ Detoxification - Acute		
☐ Detoxification - Subacute		
☐ Intensive Inpatient		
☐ Recovery House		
☐ Long-Term Treatment		
NON-RESIDENTIAL SERVICES	**ESTIMATED # OF PERSONS TO BE SERVED ANNUALLY**	**SPECIAL TREATMENT FOCUS**
☐ Outpatient		
☐ Intensive Outpatient		
☐ DUI Client Assessment		
☐ Alcohol/Drug Information School		
☐ Opiate Substitution Treatment		
☐ Treatment Alternatives to Street Crime (TASC)		
☐ Free-Standing ADATSA Assessments		
☐ Outpatient Childcare		
☐ Information and Crisis Services		
☐ Emergency Service Patrol		

PART 4- CONTRACTS

Does your agency now receive government funds, or does your agency intend to provide chemical dependency treatment services for which you will receive government funds?

☐ Yes ☐ No

If yes, indicate the source(s), e.g., federal, state, tribal, county, criminal justice, corrections, or other: _____

Please identify the certified chemical dependency treatment service(s) for which contract funds are or may be provided: _____

PART 5 – MATERIALS TO BE SUBMITTED WITH THE APPLICATION (See instructions)

A. A list with the name, address, telephone number, and title of each member of the organizational governing body.

B. **If privately owned**, a copy of the Washington State Master Business License, which authorizes the applicant to do business in this state.

C. **If privately owned**, a copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the person has

lived out-of-state within the past three years for any owner of five percent of the organizational assets.

D. **If privately owned,** a list with the name(s), address(es), telephone number(s), and percentage of ownership for each owner of five percent or more of the organizational assets.

E. For the on-site agency administrator designated by the governing body, a copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the person has lived outside of Washington State within the past three years

F. **If planning to offer detoxification or residential service**, a copy of the Residential Treatment Facility or Hospital license issued by the Washington State Department of Health (DOH), Facilities and Services Licensing Division; or in cases of nursing home facilities, the Washington State Department of Social and Health Services (DSHS).
☐ License Enclosed ☐ To follow at a later date

G. A complete copy of the agency administrative, personnel, and clinical manuals specific to the organization, agency, and treatment services at the proposed site.

H. A copy of the agency's fiscal policies and procedures as they relate to informing clients and patients of fees charged.

I. Evidence of sufficient qualified staff to deliver the chemical dependency treatment services applied for that includes:

1. A copy of an organizational chart showing each staff position, including volunteers, students, and persons on contract, by job title, lines of responsibility, the full-time equivalency percentage for each position, and how the agency relates to the governing body and any parent organization.

2. A copy of the job description for the on-site administrator and each staff person who will be providing or supervising patient care.

3. A copy of the current certificate of certification as a Chemical Dependency Professional issued by the Washington State DOH for each chemical dependency professional to be employed by your organization at the proposed initial site.
☐ Certificate(s) Enclosed ☐ To follow at a later date

   Note: The wall certificate issued by DOH is not sufficient. The certificate must include the certification expiration date.

4. **If applying as a municipal or district court probation office**, submit evidence of the employment of a probation assessment officer that meets the requirements of WAC 388-805-220.
☐ Evidence Enclosed ☐ To follow at a later date

5. **If applying for certification to provide alcohol/drug information school services**, then submit evidence of the employment of a qualified alcohol/drug information school instructor that meets the requirements of WAC 388-805-250.
☐ Evidence Enclosed ☐ To follow at a later date

J. A sample patient record for **each** certified chemical dependency treatment service applied for in this application. **Ensure you refer to the instructions for vital directions.**

K. Facility information as follows:

1. A completed Americans with Disabilities Act (ADA) Checklist for Existing Facilities.

2. A plan of the premises, which show that the chemical dependency treatment services are discrete from other, programs, and indicates the capacities of buildings for its intended uses.

3. A floor plan showing the use of each room and the location of specific facility details as listed in WAC 388-805-015(2)(l)(i-vii).

☐ Facility information enclosed ☐ To follow at a later date

L. **If applying for outpatient childcare certification**, and the agency is licensed by the Department of Social and Health Services Division of Children and Family Services (DCFS), provide a copy of the current license. *If the child care service is not currently licensed*, but the organization intends to apply to DSHS at a later date, please indicate below. *If the organization is seeking DASA certification,* then submit evidence of meeting the requirements of WAC 388-805-900 through 935.

☐ DSHS DCFS License enclosed ☐ To follow at a later date

M. **If your agency is accredited by a DASA recognized national chemical dependency accreditation body**, submit a copy of the current accreditation certificate. Also submit copies of the most recent survey findings and all follow-up correspondence.

Note: Your agency will not be eligible for deemed status under WAC 388-805-115 until your agency has been granted standard certification.

N. **An application fee of $500** must be submitted with this application, and must be in the form of a check or money order made out to the Department of Social and Health Services.

O. A copy of the cover letter used to notify the county alcohol/drug coordinator for the county where services will be provided of this application.

PART 6 – DECLARATIONS (See instructions at back of application)

I will notify DASA if changes occur in any of the information provided in Parts 1 through 6 of this application before certification occurs.

I declare that no person named in this application has had a license or certification for a chemical dependency treatment service or health care agency either denied, revoked, or suspended, as referenced in WAC 388-805-065(1)(a).

I declare that no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse, as referenced in WAC 388-805-065(1)(b).

I declare that no person named in this application is currently under investigation for having committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under Chapter 18.130.180 RCW, as referenced in WAC 388-805-065(1)(d).

I declare that the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.

Signature of on-site administrator or other responsible party	**Date**
Address	**Telephone** **( )**
Type or Print Name	**Title**

Return the original application form, one copy of the items required in **PART 5**, and the nonrefundable $500 application fee to the attention of:

Robert Geissinger, CCDCIII, Certification Specialist
Certification Section
Department of Social and Health Services
Division of Alcohol and Substance Abuse
Post Office Box 45330 (Mail Stop 45330)
Olympia, Washington 98504-5330

Note: You do not have to return the instructions with your application. Program manuals will be returned to the applicant after they are reviewed.

Privacy Notice

This notice is provided in compliance with Governor's Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this application or request.

DASA requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.

DASA also requires an applicant to submit the name, address, and telephone number for each owner of 5% or more of the organizational assets. Additionally, we require owners and the administrator to submit copies of the results of a criminal background check conducted by the Washington State Patrol. This information will be used to determine whether a specific person is a qualified applicant under WAC 388-805-065.

Applicants may decide to provide personal contact information (address, or telephone number) in lieu of business contact information. Addresses and telephone numbers identified as personal information and criminal background checks may be disclosed to parties outside of the department without written consent of the involved party.

All information collected as a part of the application or a request for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington 42.17.310(1).

Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for up to six years following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification. Information will be destroyed after that time.

Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.

Please contact Bob Geissinger if you have any questions or concerns. Contact information is provided with this application.